Critical Incident and Death Reporting Form

INSTRUCTIONS

Purpose:

Effective July 1, 2003, the **Critical Incident and Death Reporting Form** must used to report critical incidents and deaths for any person receiving mental health, developmental disabilities and/or substance abuse (mh/dd/sa) services to area authorities/county programs, as required by North Carolina Administrative Code 10A NCAC 27G .0600. This form also replaces the **Report of Death to DHHS** form, rev. 8/10/00 for reporting deaths from unnatural causes (pursuant to G.S. 122C-31) to the NC Department of Health & Human Services (DHHS).

Who must submit the form:

Facilities licensed under NC General Statutes 122C (except hospitals) and unlicensed providers of periodic or community-based mh/dd/sa services must submit the form. Failure to do so, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in administrative actions being taken against the provider's license or authorization to provide services.

Confidentiality:

Use this form according to confidentiality requirements in NC General Statutes and Administrative Code and in the Code of Federal Regulations:

- NC General Statutes 122C-52 through 56
- NC Administrative Code `10A NCAC 26B`
- Federal regulations 42 CFR Part 2 and 45 CFR Parts 160 and 164. Approved use of this form is permitted under the audit or evaluation exception of 42 CFR Part 2.53, which allows disclosure of information without client consent. Re-disclosure of information is explicitly prohibited except as provided in 42 CFR Part 2.

What/where to file:

- **Report all critical incidents, including all deaths**, to the host area authority/county program[1] and to the client's home area authority/county program[2], if different.
- **Report deaths from suicide, accident, homicide or other violence** and deaths that occur within 7 days of restraint or seclusion of a consumer to:

  1) NC Division of Facility Services (DFS), Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718, Fax: (919) 715-8077, Voice: (919) 855-3795, **and**

  2) Area authority/county program.

  NOTE: This is a change for unlicensed providers in the address for reporting deaths.

[1] The host program is the area authority/county program in whose catchment area the person is being served/supported.

[2] The home program is the area authority/county program for the catchment area of the person's legal residence.

- **Report suspected or alleged cases of abuse, neglect or exploitation of a juvenile or disabled adult** (pursuant to 42 CFR Part 488 SubpartE and 10A NCAC 3H .2001):
  1) Verbally to the county Department of Social Services in which the suspected activity occurred, **and**
  2) On this form to the area authority/county program.
- Complete all sections of the form, *except the Reportable Deaths section,* for critical incidents or deaths that *do not* have to be reported to the DFS Mental Health Licensure and Certification Section.
- Complete all sections of the form, *including the Reportable Deaths section,* for deaths that *do* have to be reported to the DFS Mental Health Licensure and Certification Section. These are deaths from suicide, accident, homicide, or other violence and deaths occurring within seven (7) days of seclusion or restraint of a consumer.

When to file:

The following table describes when and where critical incidents must be reported:

Type of Incident	Report to Area Authorities/ County Programs	Report to DFS	Report to DSS
Death from natural or unknown cause	Within 72 hours		
Death from suicide, accident, homicide or other violence	Within 72 hours	Within 72 hours	
Death within 7 days of seclusion or restraint	Within 72 hours	Immediately	
Alleged or suspected abuse, neglect or exploitation of a client	Within 72 hours		Verbally as soon as possible
Injuries requiring treatment by a physician Medication errors causing discomfort or jeopardy to a client Client absences without notification for over 3 hours Suspension or expulsion of a client from services Arrest of a client Fire or equipment failure resulting in death or injury	Within 72 hours		

How to file:

Forms may be submitted by mail, fax or *protected* email. Due to confidentiality regulations, only forms that are encrypted or password-protected may be submitted by email. You may complete the form in one of the following ways:

- ***Electronically***: The electronic version of the form is an interactive PDF document that requires that you have Adobe Reader on your computer. You can download this software for free. *Before filling out the form*, save the document with another name in order to protect your master copy of the form. Complete the renamed document by filling in the gray boxes. Submit the form to the proper agencies.
- ***Manually***: Print the blank form and type or write in the answers, making sure your answers are legible. Submit the form to the proper agencies.

SPECIFIC INSTRUCTIONS

A. Provider Information

Complete this entire section. Please note the following:

1. ***Host area authority/county program*:** Enter the name of the area authority or county program in whose catchment area the services/supports are being provided.
2. ***Director / CEO:*** Enter the name of the person in charge of the facility or business providing the service. For multiple-site agencies, enter the name of the director of the facility where the incident occurred.
3. ***Name & title of first staff person to learn of incident:*** Enter the name of the first staff person to witness the incident or learn of the incident from another person.

B. Client Information:

Provide all information requested.. Please note the following:

4. ***Weight & height:*** This information is needed *only for deaths that have to be reported to DFS*. If the height and weight are unknown, give the closest estimate possible.
5. ***All mh/dd/sa diagnoses:*** Diagnoses should include both admitting and current diagnoses for which the client is receiving mh/dd/sa services. Enter diagnoses using descriptive terms rather than diagnostic codes.
6. ***Consumer's home area authority/county program:*** Enter the name of the area authority or county program for the area of the person's legal residence, or in which the county Department of Social Services with custody is located, if different from above.

C. Type of Incident:

Complete each section that is applicable to the incident. Note that within each section, you may be asked to check *only one* box **or** *all that apply*.

7. ***Death:*** Complete this section when you become aware of a consumer's death. Check only one cause of death.

   If the death is due to suicide, accident, homicide or other violence or occurs within 7 days of restraint or seclusion of the consumer:

   (1) enter the consumer's weight and height in the *Client Information* section;

   (2) Complete the *Reportable Deaths* section on page 2; and

8. (3) send the form to both the area authority/county program and to DFS.***Abuse, Neglect or Exploitation:*** Complete this section for any situation in which you suspect or someone alleges that a consumer has been abused, neglected or exploited. Check as many boxes in this section as applicable.

9. ***Injury Requiring Treatment by Physician:*** Complete this section whenever a consumer is injured seriously enough to require treatment by a physician or person authorized to act on behalf of a physician. Do not report minor injuries treated by nursing staff.

10. ***Medication Errors:*** Complete this section, reporting only those medication errors that cause the consumer discomfort or that place the consumer in jeopardy of death or permanent impairment. Check *only one* of the following errors:

    (a) Missed dose – Any dose of a medication not given to a client within one hour of the prescribed time.

    (b) Wrong dosage - Any dosage of a medication that does not follow the prescribed order

    (c) Wrong medication – Any incorrect or expired prescription medication administered to a client

11. ***Other Incidents:*** Complete this section whenever a client is absent without notification, suspended or expelled from services, arrested, or injured/killed due to fire or equipment failure in the provider's facility. Check as many boxes in this section as applicable.

    For suspensions of a client from services, check the box and also enter the length of the suspension.

D. Restraint & Seclusion:

Complete this section *only* for incidents defined in the *Type of Incident* section. Other instances of restraint or seclusion must be documented in the client record, but do not need to be reported on this form. However, if you use a standardized form for documentation of restraint and seclusion, attach that document to this form when the use of restraint or seclusion is involved in a critical incident.

E. Reportable Deaths:

Complete this section *only* when:

- A death occurs from suicide, accident, homicide or other violence **or**
- A death occurs within 7 days of seclusion or restraint of the client

12. ***Most recent admission to state mh/dd/sa facility and/or hospital for physical illness***: If consumer has not had admissions, check N/A.

13. ***Physical illnesses/conditions***: Using descriptive terms to list those illnesses and conditions that were diagnosed by a physician prior to the client's death, regardless of whether or not they contributed to the death.

F. Circumstances of Incident:

Providers using standardized internal *accident/injury forms* may attach that form in lieu of answering this question, as long as all of the information below is included on the form.

14. ***Location:*** Check the box that indicates where the incident occurred. If the location does not fit one of the defined categories, check *Other* and provide a short description of the location (for example, *church*).

15. ***Description:*** Provide a detailed description of the incident, including:

- Who was involved: Include the names of people actively involved in causing, being injured by and responding to the incident and the names of people who witnessed the incident.
- What happened: Provide as much detail as possible.
- Why it happened: Include any actions or circumstances that led up to the incident, contributed to it or appear to have caused it.
- Other relevant information: Include any information that can help resolve the incident and prevent future incidents of a similar nature.

Attach extra pages, labeled *Description of Incident*, if necessary to provide an accurate account of the incident.

16. ***Injuries:*** Indicate the location of any bruises, cuts, scratches, injuries or other marks on the client as a result of the incident by circling the appropriate area on the figures provided. NOTE: If using the electronic version of the form, click on boxes as close to the location(s) of injuries as possible.

G. Internal Response:

17. ***Investigation:*** Describe what has been done so far to determine why the incident occurred. If the investigation is not complete, include the date that the provider expects to have completed the internal investigation. If no investigation seems necessary, explain why. Attach extra pages, labeled *Investigation* if necessary.

18. ***Corrective Measures:*** Provide a short description of actions that the provider has taken to prevent future incidents of a similar nature. Also include the name(s) of the staff who will be responsible for implementing and overseeing the corrective measures. If corrective measures are planned, but not yet implemented, include a projected date of implementation. Attach extra pages, labeled *Corrective Measures* if necessary.

19. ***Other Authorities or Persons Notified:*** Check the box beside any individuals or agencies that have been notified of the incident. Include the date of the notification and contact names where requested. NOTE: The parent or legally responsible person, client's home area program and case manager (if there is one) should always be notified of any incidents.

Signature:

The staff person who fills out the form must provide his/her title, name and signature on the form. This does not need to be the same person who first witnessed or learned of the incident.

Direct any questions to:

DMH/DD/SAS Accountability Team - Phone: (919) 881-2446 FAX: (919) 881-2451

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Look for Frequently Asked Questions (FAQ) on the DMH/DD/SAS website.
http://www.dhhs.state.nc.us/mhddsas/